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EXAMINER	
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Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary

Applicati n N .

09/812,704

Applicant(s)

LEWIS ET AL.

Examiner

Luke Gilligan

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-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If the period for reply specified above is less than thirty (30) days, a reply within the statutory minimum of thirty (30) days will be considered timely.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133).
- Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

- 1) ☐ Responsive to communication(s) filed on ____.
- 2a) ☐ This action is **FINAL**. 2b) ☒ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

- 4) ☒ Claim(s) 1-56 is/are pending in the application.
- 4a) Of the above claim(s) ____ is/are withdrawn from consideration.
- 5) ☐ Claim(s) ____ is/are allowed.
- 6) ☒ Claim(s) 1-56 is/are rejected.
- 7) ☐ Claim(s) ____ is/are objected to.
- 8) ☐ Claim(s) ____ are subject to restriction and/or election requirement.

Application Papers

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on ____ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.
- Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).
- 11) ☐ The proposed drawing correction filed on ____ is: a) ☐ approved b) ☐ disapproved by the Examiner.
- If approved, corrected drawings are required in reply to this Office action.
- 12) ☐ The oath or declaration is objected to by the Examiner.

Priority under 35 U.S.C. §§ 119 and 120

- 13) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All b) ☐ Some * c) ☐ None of:
1. ☐ Certified copies of the priority documents have been received.
2. ☐ Certified copies of the priority documents have been received in Application No. ____.
3. ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).
- * See the attached detailed Office action for a list of the certified copies not received.
- 14) ☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. § 119(e) (to a provisional application).
- a) ☐ The translation of the foreign language provisional application has been received.
- 15) ☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. §§ 120 and/or 121.

Attachment(s)

- 1) ☒ Notice of References Cited (PTO-892)
- 2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
- 3) ☒ Information Disclosure Statement(s) (PTO-1449) Paper No(s) 41/2
- 4) ☐ Interview Summary (PTO-413) Paper No(s). ____.
- 5) ☐ Notice of Informal Patent Application (PTO-152)
- 6) ☐ Other: .

Claims 1-56 have been examined.

Claim Rejections - 35 USC § 101

1. 35 U.S.C. 101 reads as follows:

Whoever invents or discovers any new and useful process, machine, manufacture, or composition of matter, or any new and useful improvement thereof, may obtain a patent therefor, subject to the conditions and requirements of this title.

2. Claims 1, 5-13, 17-25, 35, and 36 rejected under 35 U.S.C. 101 because the claimed invention is directed to non-statutory subject matter.

The basis of this rejection is set forth in a two-prong test of:

- (1) whether the invention is within the technological arts; and
- (2) whether the invention produces a useful, concrete, and tangible result.

3. For a claimed invention to be statutory, the claimed invention must be within the technological arts. Mere ideas in the abstract (i.e., abstract idea, law of nature, natural phenomena) that do not apply, involve, use, or advance the technological arts fail to promote the "progress of science and the useful arts" (i.e., the physical sciences as opposed to social sciences, for example) and therefore are found to be non-statutory subject matter. For a process claim to pass muster, the recited process must somehow apply, involve, use, or advance the technological arts.
4. In the present case, claims 1, 13, and 25 only recites an abstract idea. The recited steps of merely gathering data from physicians, identifying physicians who are at a greater risk of not receiving a predetermined, and modifying the physicians behavior does not apply, involve, use, or advance the technological arts since all of the recited steps can be performed in the mind of the user or by use of a pencil and paper. These steps only constitute an idea of how to manage the behavior of physicians. Furthermore, claims 5-12, 17-24, 35 and 36 fail to remedy the deficiencies of claims 1, 13 and 25.

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5. Additionally, for a claimed invention to be statutory, the claimed invention must produce a useful, concrete, and tangible result. Although the recited process produces a useful, concrete, and tangible result, since the claimed invention, as a whole, is not within the technological arts as explained above, claims 1, 5-13, 17-25, 35, and 36 are deemed to be directed to non-statutory subject matter.

Claim Rejections - 35 USC § 112

6. The following is a quotation of the second paragraph of 35 U.S.C. 112:

The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

7. Claims 26-34 are rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

8. Claim 26 recites the limitation "the ancillary medical networks" in lines 5-6 and 8-9. There is insufficient antecedent basis for this limitation in the claim. Claims 27-34 contain the same deficiencies as claim 26 through dependency and, as such, are rejected for the same reasons.

Claim Rejections - 35 USC § 102

9. The following is a quotation of the appropriate paragraphs of 35 U.S.C. 102 that form the basis for the rejections under this section made in this Office action:

A person shall be entitled to a patent unless –

(b) the invention was patented or described in a printed publication in this or a foreign country or in public use or on sale in this country, more than one year prior to the date of application for patent in the United States.

10. Claims 25-27, 35-37, and 46-49 are rejected under 35 U.S.C. 102(b) as being anticipated by Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman).

11. As per claim 25, Freeman teaches a method of optimizing the profitability of an insurance network having a plurality of physicians in a healthcare practice participating therein by managing ancillary medical costs, the method comprising the steps of: gathering data from each of a plurality of physicians in the healthcare practice participating in the insurance network regarding management of ancillary medical costs (see column 3, lines 10-15); modifying the plurality of physicians' in the healthcare practice management behavior regarding ancillary medical costs that are not profitable for the insurance network (see column 9, lines 16-19, in particular, "insuring that the entities meet the requirements set by the cooperative"); and providing a financial incentive to the insurance network and the plurality of physicians in the healthcare practice participating in the insurance network to modify the plurality of physicians; management behavior of ancillary medical costs that are not as profitable to the insurance network (see column 7, lines 38-52).

12. As per claim 26, Freeman teaches the method of claim 25 as described above, wherein the step of gathering data includes gathering information regarding the ancillary medical costs of each of the plurality of physicians participating in the insurance network from databases associated with the insurance networks, the databases positioned on servers in communication with each of a plurality of ancillary medical facilities participating in the insurance networks (see column 6, lines 35-41).

13. As per claims 27, Freeman teaches the method of claim 26 as described above, further comprising identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network whose management of ancillary medical costs are not profitable to the insurance network (see column 9, lines 16-19, in particular, "insuring that the entities meet the requirements set by the cooperative").

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14. As per claim 35, Freeman teaches the method of claim 25 as described above, further comprising updating each of the plurality of physicians in the healthcare practice of new ancillary medical procedures that are more profitable to the insurance network (see column 5, line 58 – column 6, line 7).

15. As per claim 36, Freeman teaches the method of claim 35 as described above, wherein the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

16. As per claim 37, Freeman teaches a healthcare management optimization system for a healthcare practice including a plurality of physicians participating in an insurance network comprising: a first database comprising ancillary medical procedures that are preferred by the insurance network (see column 6, lines 35-41); a second database comprising ancillary medical costs of each of the plurality of physicians participating in the insurance network (see column 6, lines 35-41); an analyzer in communication with the first and second databases for analyzing the data in the first and second databases and comparing the ancillary medical procedures that are preferred by the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network to thereby identify ancillary medical costs of the physicians that are not preferred by the insurance network (see column 9, line 16 – column 10, line 5); and managing means responsive to the analyzer for managing the ancillary medical costs of the healthcare practice to thereby modify the ancillary medical costs of the physicians in the healthcare practice to be more profitable to the insurance network (see column 9, line 16 – column 10, line 5).

17. As per claim 46, Freeman teaches a healthcare management optimization system for a healthcare practice including a plurality of physicians participating in an insurance network

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comprising: a server having at least one database (see figures 1 and 2); a communications network positioned to be in communication with the server (see figures 1 and 2); a plurality of computers positioned to be in communication with the communications network, each including a user interface responsive to a user (see figures 1 and 2); an updater positioned on the server and responsive to the user interface updating each of the plurality of physicians in the healthcare practice of any changes in the management of ancillary medical costs that are preferred by the insurance network (see column 6, lines 1-14); and recommending means positioned on the server and responsive to the user interface for recommending to each of the plurality of physicians alternative ancillary medical procedures that are preferred by the insurance network (see column 9, lines 16-21).

18. As per claim 47, Freeman teaches the system of claim 47 as described above, wherein the at least one database comprises a first and second database, the first database including ancillary medical procedures that are more preferred by the insurance network and wherein the second database includes ancillary medical costs of each of the plurality of physicians participating in the insurance network (see column 9, line 16 – column 10, line 5).

19. As per claim 48, Freeman teaches the system of claim 47 as described above, further comprising an analyzer in communication with the first and second databases for analyzing the data in the first and second databases and comparing the ancillary medical procedures that are preferred by the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network with the ancillary medical costs of the plurality of physicians participating in the insurance network to thereby identify ancillary medical costs of the physicians that are not preferred by the insurance network (see column 9, line 16 – column 10, line 5).

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20. As per claim 49, Freeman teaches the system of claim 48 as described above, further comprising managing means responsive to the analyzer for managing the ancillary medical costs of the healthcare practice to thereby modify the ancillary medical costs of the physicians in the healthcare practice to be more profitable to the insurance network (see column 9, line 16 – column 10, line 5).

Claim Rejections - 35 USC § 103

21. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negated by the manner in which the invention was made.

22. Claims 1, 2, 5-14, 17-23, 24, 38, and 50 are rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman) in view of Segal and Wang, **Influencing Physician Prescribing** (hereinafter Segal).

23. As per claim 1, Freeman teaches a method of managing a healthcare practice participating in an insurance network to optimize profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs, the method comprising: gathering data from each of a plurality of physicians in the healthcare practice participating in the insurance network regarding management of the pharmacy costs (see column 3, lines 10-15); identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that prescribes medications that don't follow requirements of the insurance network (see column 9, lines 17-21 and column 10, lines 2-5). Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined

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reimbursement amount for the pharmacy costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for pharmacy costs from an insurance net work by prescribing medications that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the pharmacy costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the pharmacy costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the steps of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

24. As per claim 2, Freeman in view of Segal teach the method of claim 1 as described above. Freeman further teaches gathering information regarding the pharmacy costs of each of the plurality of physicians in the healthcare practice participating in the insurance network from a database associated with a pharmacy network, the database positioned on a server in communication with each of a plurality of pharmacies in the pharmacy network participating in the insurance network (see column 6, lines 35-41).

25. As per claim 5, Freeman in view of Segal teach the method of claim 1 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative prescription medication. Segal discloses modifying physicians management behavior regarding the pharmacy costs comprises educating the at

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least one physician on the benefits of alternative prescription medications using research literature for comparing the alternative medications to the prescribed medications and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative prescription medications (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

26. As per claim 6, Freeman in view of Segal teach the method of claim 5 as described above. Freeman does not explicitly teach modifying a physician's management behavior by preparing a list of prescription medications for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprising preparing a list of prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

27. As per claim 7, Freeman in view of Segal teach the method of claim 6 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom prescription medication forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom prescription medications forms that include prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this

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teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

28. As per claim 8, Freeman in view of Segal teach the method of claim 7 as described above. Freeman does not explicitly teach modifying the at least one physician's management behavior by preparing a list of common prescription medications that are approve by a plurality of insurance networks. Segal teaches modifying the at least one physician's management behavior by preparing a list of common prescription medications that are approve by a plurality of insurance networks (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

29. As per claim 9, Freeman in view of Segal teach the method of claim 7 as described above. Freeman further teaches analyzing a patient's prescription history to thereby avoid possible adverse prescription medication reactions (see column 8, lines 54-67).

30. As per claim 10, Freeman in view of Segal teach the method of claim 9 as described above. Freeman does not explicitly teach identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursement and amending and discontinuing the at least one patient's prescription medications that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursement and amending and discontinuing the at least one patient's prescription medications that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of

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healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 1.

31. As per claim 11, Freeman in view of Segal teach the method of claim 10 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present prescription medication is discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

32. As per claim 12, Freeman in view of Segal teach the method of claim 1 as described above. Freeman further teaches updating each of the plurality of physicians in the healthcare practice of any changes in the management of pharmacy costs from the insurance network (see column 5, lines 58 – column 6, line 7).

33. Claims 13, 14, and 17-23 contain substantially similar limitations for managing ancillary medical costs as claims 1, and 5-12 and, as such, are rejected for similar reasons as given above.

34. As per claim 24, Freeman in view of Segal teach the method of claim 20 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

35. As per claim 38, Freeman teaches the system of claim 37 as described above. Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for ancillary medical costs from an insurance net work by performing ancillary medical procedures that are detrimental to receiving the

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predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the ancillary medical costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the feature of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

36. As per claim 50, Freeman teaches the system of claim 49 as described above. Freeman does not explicitly teach identifying physicians at a greater risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network and modifying the physicians management behavior to reduce the risk of not receiving the reimbursement amount. Segal discloses a model for identifying physicians at a risk not receiving a predetermined reimbursement amount for ancillary medical costs from an insurance net work by performing ancillary medical procedures that are detrimental to receiving the predetermined reimbursement amount (see paragraph 7, as numbered by Examiner and Figure 2, in particular, the monitoring of therapy); and modifying physician's management behavior regarding the ancillary medical costs to substantially reduce the risk of not receiving the predetermined reimbursement amount for the ancillary medical costs from the insurance network (see paragraphs 7 and 66, and Figure 2). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the feature of identifying and modifying physician behavior as described by Segal into the invention

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of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

37. Claims 28 and 29 are rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman) in view of Glass, Pieper, and Berlin, **Incentiv-Based Physician Compensation Models** (hereinafter Glass).

38. As per claim 28, Freeman teaches the method of claim 27 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater than the average ancillary medical cost. Glass discloses a model for calculating an average ancillary medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this step into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

39. As per claim 29, Freeman teaches the method of claim 27 as described above. Freeman does not explicitly teach identifying at least one physician having the highest ancillary medical costs within the healthcare practice. Glass teaches identifying at least one physician having the highest ancillary medical costs within the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare

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management to combine this with the method of Freeman for the reasons give above with respect to claim 3.

40. Claims 3, 4, 15, 16, 30-34, 39-45, and 51-56 are rejected under 35 U.S.C. 103(a) as being unpatentable over Freeman, Jr. et al., U.S. Patent No. 6,012,035 (hereinafter Freeman) in view of Segal and Wang, **Influencing Physician Prescribing** (hereinafter Segal) and further in view of Glass, Pieper, and Berlin, **Incentiv-Based Physician Compensation Models** (hereinafter Glass).

41. As per claim 3, Freeman in view of Segal teach the method of claim 2 as described above. Freeman does not explicitly teach calculating an average pharmacy cost per physician and determining which physicians are a predetermined percentage greater that the average pharmacy cost. Glass discloses a model for calculating an average pharmacy cost per physician for healthcare practices, and identifying the physicians that have pharmacy costs that are a predetermined percentage greater than the average pharmacy costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this step into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

42. As per claim 4, Freeman in view of Segal and Glass teach the method of claim 3 as described above. Freeman does not explicitly teach identifying at least one physician having the highest pharmacy costs within the healthcare practice. Glass teaches teach identifying at least one physician having the highest pharmacy costs within the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare

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management to combine this with the method of Freeman for the reasons give above with respect to claim 3.

43. Claims 15 and 16 contain substantially similar limitations for managing ancillary medical costs as claims 3 and 4 and, as such, are rejected for similar reasons as given above.

44. As per claim 30, Freeman in view of Glass teaches the method of claim 28 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures with current ancillary medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the steps of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

45. As per claim 31, Freeman in view of Glass and Segal teach the method of claim 30 as described above. Freeman does not explicitly teach modifying a physician's management behavior by preparing a list of ancillary medical procedures for the physician. Segal discloses the step of modifying at least on physician's management behavior further comprising preparing a list of ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs (see

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paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

46. As per claim 32, Freeman in view of Glass and Segal teach the method of claim 31 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

47. As per claim 33, Freeman in view of Glass and Segal teach the method of claim 32 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the

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invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 30.

48. As per claim 34, Freeman in view of Glass and Segal teach the method of claim 33 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

49. As per claim 39, Freeman in view of Segal teach the system of claim 38 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater than the average ancillary medical cost. Glass discloses a model for calculating an average ancillary medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this feature into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

50. As per claim 40, Freeman in view of Segal and Glass teach the system of claim 39 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures

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with current ancillary medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the features of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

51. As per claim 41, Freeman in view of Segal and Glass teach the system of claim 40 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 40.

52. As per claim 42, Freeman in view of Segal and Glass teach the system of claim 41 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put

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the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 40.

53. As per claim 43, Freeman in view of Glass and Segal teach the system of claim 42 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

54. As per claim 44, Freeman in view of Glass and Segal teach the system of claim 42 as described above. Freeman further teaches updating each of the plurality of physicians in the healthcare practice of new ancillary medical procedures that are more profitable to the insurance network (see column 5, line 58 – column 6, line 7).

55. As per claim 45, Freeman in view of Glass and Segal teach the system of claim 44 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

56. As per claim 51, Freeman in view of Glass and Segal teach the system of claim 50 as described above. Freeman does not explicitly teach calculating an average ancillary medical cost per physician and determining which physicians are a predetermined percentage greater than the average ancillary medical cost. Glass discloses a model for calculating an average ancillary medical cost per physician for healthcare practices, and identifying the physicians that have ancillary medical costs that are a predetermined percentage greater than the average

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ancillary medical costs per physician for the healthcare practice (see paragraph 51). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate this feature into the method of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

57. As per claim 52, Freeman in view of Glass and Segal teach the system of claim 51 as described above. Freeman does not explicitly teach modifying the physicians management behavior using education of benefits of alternative ancillary medical procedures. Segal discloses modifying physicians management behavior regarding the ancillary medical costs comprises educating the at least one physician on the benefits of alternative ancillary medical procedures using research literature for comparing the alternative ancillary medical procedures with current ancillary medical procedures and further comprises organizing continued medical education classes to educate each of the plurality of physicians in the healthcare practice on the benefits of the alternative ancillary medical procedures (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to incorporate the features of identifying and modifying physician behavior as described by Segal into the invention of Freeman. One of ordinary skill in the art would have been motivated to enhance the invention of Freeman as such for the purpose of lowering overall prescription costs to benefit the cooperative (see column 4, lines 30-37).

58. As per claim 53, Freeman in view of Glass and Segal teach the system of claim 52 as described above. Freeman does not explicitly teach modifying a physician's management behavior by providing custom ancillary medical procedure forms for the physician. Segal discloses the step of modifying at least one physician's management behavior further comprises providing custom ancillary medical procedure forms that include ancillary medical procedures

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that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the ancillary medical costs (see paragraph 61). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 52.

59. As per claim 54, Freeman in view of Glass and Segal teach the system of claim 53 as described above. Freeman does not explicitly teach identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement. Segal teaches identifying at least one patient whose present ancillary medical procedures put the at least one physician at risk for not receiving the predetermined reimbursement and amending the at least one patient's ancillary medical procedures that put the physician at risk for not receiving the predetermined reimbursement (see paragraphs 6 and 7). It would have been obvious to one of ordinary skill in the art of healthcare management at the time of the invention to combine this teaching of Segal with the invention of Freeman for the reasons given above with respect to claim 52.

60. As per claim 55, Freeman in view of Glass and Segal teach the system of claim 54 as described above. Segal further teaches mailing a first and second letter on a physician's letterhead informing the pharmacy and patient that the patient's present ancillary medical procedures are discontinued (see paragraphs 6 and 7, it is assumed that this is a standard procedure for discontinuing a course of medication).

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61. As per claim 56, Freeman in view of Glass and Segal teach the system of claim 54 as described above. Freeman further teaches the ancillary medical costs include any costs taken from the group listed in claim 36 (see column 8, lines 44-53).

Conclusion

62. The prior art made of record and not relied upon is considered pertinent to applicant's disclosure.

- Teagarden et al. teach a system for implementing managed care in the health care and pharmacy industry.
- Trusheim et al. teach a system for managing the healthcare of a group of patients.
- Landon et al. disclose a model for the effects of managed care on healthcare organization.
- Rice discloses various physician payment policies.

63. Any inquiry concerning this communication or earlier communications from the examiner should be directed to Luke Gilligan whose telephone number is (703) 308-6104. The examiner can normally be reached on Monday-Friday 8am-5:30pm.

64. If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on (703) 305-9588. The fax phone numbers for the organization where this application or proceeding is assigned are (703) 305-7687 for regular communications and (703) 305-7687 for After Final communications.

65. Any inquiry of a general nature or relating to the status of this application or proceeding should be directed to the receptionist whose telephone number is (703) 308-1113.

Application/Control Number: 09/812,704

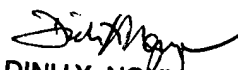
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CLG

March 24, 2003



DINH X. NGUYEN
PRIMARY EXAMINER